M O U N T A U B U R N H O S P I T A L

Jeanette G. Clough
President & CEO

May 23, 2012

Aron Boros
Commissioner
Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116

Dear Commissioner Boros,

Thank you for requesting Mount Auburn Hospital's written testimony to the questions posed by the Division of Health Care Finance and Policy and the Office of the Attorney General in conjunction with the State's public hearings concerning health care provider and insurer costs and cost trends.

The Trustees and staff of Mount Auburn Hospital hope that our responses are helpful to you as we all seek to understand more about the dynamic health care environment within Massachusetts. Our State is a national leader for medical education, research, quality, safety, and compassionate care. We are optimistic that we can work together to mitigate cost growth without jeopardizing the high standard of health care we enjoy in Massachusetts.

Please find attached our responses to the questions in "Exhibit B" and Exhibit C", which as President & CEO of Mount Auburn Hospital, I submit under the pains and penalties of perjury. We stand ready to provide further input if necessary

Yours truly,

Jeanette G. Clough
President & CEO

Attachment(s)

A Teaching Hospital of
Harvard Medical School

330 Mount Auburn Street
Cambridge, MA 02138
(617) 492-3500 Main Number
(617) 499-5700 Administration
(617) 499-5422 Fax
jclough@mah.harvard.edu

Cost Trends 2012 – Preliminary Questions for Written Testimony Witnesses

Exhibit B

Written Testimony of the Mount Auburn Hospital

Submitted to the Division of Health Care Finance and Policy

May 23, 2012

Hospitals & Other Providers

Trends in Premiums and Costs

1. *After reviewing the preliminary reports, please provide commentary on any finding that differs from your organization's experience. Please explain the potential reasons for any differences.*

   The TME portrayed for the Mount Auburn Cambridge IPA (MACIPA) with which the Mount Auburn Hospital shares risk looks high. Since we cannot exactly replicate the health plan's methodology, specifically related to adjustment for relative health status adjustment, we were unable to tie our experience to what is reported. Generally speaking, when we compare our underlying medical expenses to other provider entities in the plan's network, we would not be a high cost provider. Some of the dollars included in the MACIPA TME could be dollars that would be absorbed in the insurer's administrative component in other provided units, as we are delegated to provide some of the services otherwise provided by the health plan. The payments we receive from the health plan to provide these services (among other payments) have been added to medical claims which make the MACIPA TME look higher than it might without these payments. Further, our understanding is that the TME is only reported for HMO enrolled lives. Since most of the driver of the differential between our underlying medical costs and TME is due to non-claims payments, if these payments for creating cost savings to trend and for quality performance were spread across all the lines of business with the health plans, our costs would be low relative to the providers in our market area. For example, if our underlying rates are at the average (factor of 1.0) for the State, but payments we receive under value-based arrangements bring the reimbursement to a factor of 1.5 for those services that come under the risk arrangement umbrella, we would be viewed as having payments (TME) 1.5 times the average. However, if those (HMO risk) arrangements only account for 30% of the revenue from the insurer and the rest of our payments are at the 1.0 factor, our overall payment factor would be 1.15, slightly higher than average, but not 1.5 times the average. If we are being compared to other providers who are on a fee-for-service basis and whose fees are at a factor of 1.3 for all their lines of business, if we are compared to them just on the HMO line where we earn value payments, our rates would look higher (and thus the TME): 1.5 vs. 1.3. But if we measured the payments (and assigned TME) of non-HMO patients, we indeed are lower: 1.15 vs. 1.3.

2. *What specific actions has your organization taken to reduce the cost of services? Please also describe what impact, if any, these strategies have had on service quality and patient outcomes. What current factors limit the ability of your organization to execute these strategies effectively?*

See Ex B2 for cost avoidance.

Our continuous efforts at cost reduction have been a very strong and deliberate focus touching every department and service at the Hospital. Our goals include reduction of inefficiency and waste as well as to implement effective programs to reduce costs of delivering clinical care as well as reducing costs to operate the Hospital.

Our first focus is on providing a safe environment while avoiding harm and reducing cost through improved clinical outcomes and eliminating inefficiency. Our quality and patient safety programs have demonstrated improved outcomes for infection prevention (CLABSI, CAUTI, VAP, C-DIFF, MRSA and other HAIs and community acquired infections) through decreasing cross contamination, preventative screenings and vaccination projects, following national standards and protocols for bundling and other infection reduction programs, partnering with skilled nursing facilities and our pre-and post-hospital providers to enhance infection prevention, benchmarking and reporting data to all staff and MDs, and a variety of other methods. Our efforts to reduce error and harm from medication administration have resulted in near six sigma levels of safety for several years with computerized provider order entry (CPOE), automated inventories and direct to pharmacy ordering, a closed unit distribution system (PYXIS) and bedside medication verification (BMV) with bar coding and automated medication administration recording (EMAR). We actively report on these outcomes and also track the financial impact of our cost avoidance as shown on Exhibit B2.

Our efforts to reduce the cost of employee health insurance have also shown success. Mount Auburn self insures for employee health insurance and has introduced an employee wellness program to encourage and promote healthy lifestyles and behaviors. Staff education regarding benefits, health and nutrition education along with programs for weight management and bariatric surgery have resulted in a reduction year over year in the rate of increase of the Hospital's cost of health insurance, while keeping employee costs flat. This year we will be rebidding our third party claims administrative contract to try to obtain additional savings.

The Hospital participates in the Voluntary Hospitals of America (VHA) purchasing cooperative and with great collaboration and cooperation with our physicians Mount Auburn has worked to reduce multiple inventories and streamline preference items to gain better pricing while achieving similar or even better clinical outcomes. Non-clinical purchasing for food, office supplies, and other items has also been a focus for collaboration among hospitals and health systems in VHA Northeast and VHA nationally. This has been especially successful in keeping the costs of utilities under control. Group purchasing of electricity and co-generating energy using both gas and oil allow costs to stay under control. Similarly the Hospital participates in numerous energy saving programs to reduce utilization of lighting/electricity and water. Recycling and "green" initiatives have increased savings every year for the last 10 years.

The Hospital continues to operate a blood banking service with a loyal and growing group of blood donors. While the cost of blood and blood products from outside vendors continues to

rise each year Mount Auburn has managed to stem this tide through generating about 30% of our blood supply through our donor program.

Finally, our pharmacy costs are monitored carefully as the cost of drugs is one of the highest expense areas. Drugs for hospital use are purchased through our VHA cooperative however often it is difficult to control increases in these expenses. A significant issue has been the unrelenting and unsafe situation with drug shortages. Hospitals around the country are facing daily shortages of critical drugs forcing physicians and pharmacies to order greater quantities and purchase drugs outside of what would normally be stocked and dispensed. Far beyond just a cost issue this is a serious patient quality of care and safety issue that has yet to be fully addressed by regulatory or legislative means.

Similarly, working against our efforts at cost reduction has been the unrelenting pressures on expenses from medical claims reviews and audits. Over the past three years the number of payer programs to retrospectively review (audit) medical claims has exploded. Medicare, Medicaid, and Massachusetts based commercial plans all are engaged in continuous auditing programs with different criteria for medical necessity, DRG review, and bundling/unbundling of coded claims. Each institution must manage a huge number of claims that are subject to this process and under rigid filing limits or response times that, if not met, result in an entire claim rejection and no appeal rights. Each payer has its own rules regarding record submission including creation of secure web portals for transfers, creating special CDs, or even individual records photocopied and packaged separately and sent via USPS. New staff must be hired and trained and new electronic systems must be created to manage the status and adjudication as well as track the claim and cash associated with delayed payments or requests for more data. Appeals employees have also been added to respond to appeals for additional data often resulting in multiple responses and multiple layers of paperwork associated with one individual record. Reimbursement is often held up for six to twelve months while appeals are conducted. These are just a sampling of our entire cost reduction initiatives and some of the barriers we face. Our newest initiative is around testing and the underuse and/or overuse of various tests in the care of the patient. It is too early to quote specific findings or results but we are in the early stages and hope to have data during CY13.

3. *When calculating Total Medical Expense (TME), we found a wide variation in health-status adjusted TME by provider group and that a large portion of patient volume is clustered in the most expensive quartile(s) of providers. Please share your organization's reaction to these findings.*

TME builds in underlying price differentials. Also, where providers are under global budgets, nascent contracts may include payments other than medical claims – such as infrastructure payments – to allow provider organizations to re-tool for new contract models.

In our own market, underlying medical claims include payments to brand-name providers that have prices higher than our own, and one of our challenges is to keep more care local where prices are lower.

4. *Please explain the main factors for any changes in annual TME that your organization has experienced. What specific efforts has your organization made to lower or reduce the growth in TME? What has been the result of such efforts?*

   When you focus on the underlying medical claims, we have seen a big reduction in the medical cost trends for our population. The hospital in conjunction with its IPA has undertaken many efforts to reduce the medical cost trend. At the IPA, staff is involved in identifying high risk patients and assigning care managers to those patients to help them avoid hospitalization and trips to the emergency department. Staff also follow-up with patients after they have been discharged home from the hospital to make sure they have follow-up scheduled with their PCP. We have engaged the services of two entities that specialize in following-up with patients in their homes who are at high risk for re-hospitalization. The IPA also has on staff a clinical pharmacist who works with the PCPS and other prescribing physicians to help optimize drug regimens and move patients to clinically equivalent but lower cost drugs, where appropriate. None of these services would be reimbursable under a fee-for-service arrangement, but these investments make sense under a global budget.

   The hospital and its physician community have worked together to improve electronic communication to allow for more timely access to each other's information about patients we are jointly caring for but in different settings. We have put case managers in the ED to assist in patient follow-up care to ensure that patients have a safe setting to return to if we can avoid hospitalization. The entire surplus that has been generated by any global payment arrangement has been reinvested to allow the hospital to provide safer, higher quality care, better access to services and higher patient satisfaction. All these investments have been made to ensure that we can provide high quality, high value patient care into the future.

Health System Integration

5. *How ready does your organization feel it is to join, affiliate with, or become an Accountable Care Organization (ACO)? Please explain.*

   Our organization is already an ACO.

   a. *Is your organization participating in the Medicare Shared Savings ACO project?*
      Yes, we are participating with our IPA as a Pioneer ACO.
   b. *If your organization doesn't feel ready to join any type of ACO, what types of supports or resources would it need to be able to join one?*

6. *Does your organization have any direct experience with alternative payment methods (bundled payments, global payments, etc.)? What have been the effects in terms of health care cost, service quality, patient outcomes and your organization's performance?*

Yes, Mount Auburn Hospital has many years' experience with global payments. We believe that managing under these payment arrangements has allowed us to create high value, high quality care. Our patient outcome and patient satisfaction scores as measured by all the publically reported methodologies exceed the national and local scores. As mentioned above, our success in managing under these arrangements has allowed us to invest in our plant and services.

7. *Please comment on how your organization is developing formal arrangements or affiliations with other health care providers to provide care under global contracts or other alternative payment methods.*

   We have a formal clinical collaboration agreement with a large physician group in our service area to improve communication and patient management. We are also exploring tertiary arrangements for services not available at our hospital.

8. *What have been the effects of the recent proliferation of limited or tiered network plans on your organization, with regard to how you evaluate performance internally and patient access to care?*

   Some of these arrangements have led to fragmented care, particularly the limited networks that allow patients to select any primary care provider but then require that they be referred out to specialists and hospitals not affiliated with the PCP when they need care beyond the PCP. The new limited and tiered arrangements need to be thought out carefully and fully explained before patients select plans, so they understand the new rules.

9. *Given the proliferation of risk contracting, to what extent is your organization participating in global contracts that include "atypical" healthcare providers (e.g., behavioral health, oral health, home health care, etc.)? If your organization participates in a risk contract, how are supporting services, such as behavioral health and home health care, addressed?*

   The global contracts in which we participate all include home care, some oral health, but mostly exclude behavioral health. Only our Medicare arrangements include some or all behavioral health under the global budgets. In the commercial plans, where BH is excluded, the health plans manage that benefit.

Health Care Quality

10. *Are there specific areas of care for which you believe there are critical gaps in quality measurement?*

    Outpatient care/ambulatory practice is an area that could be covered by more quality measurement. We also believe that free-standing entities such as ambulatory surgi-centers and free standing MRI facilities should be required to submit information that compare to hospital

quality outcomes. Certain surgical subspecialties are not well measured, including indications for surgery.

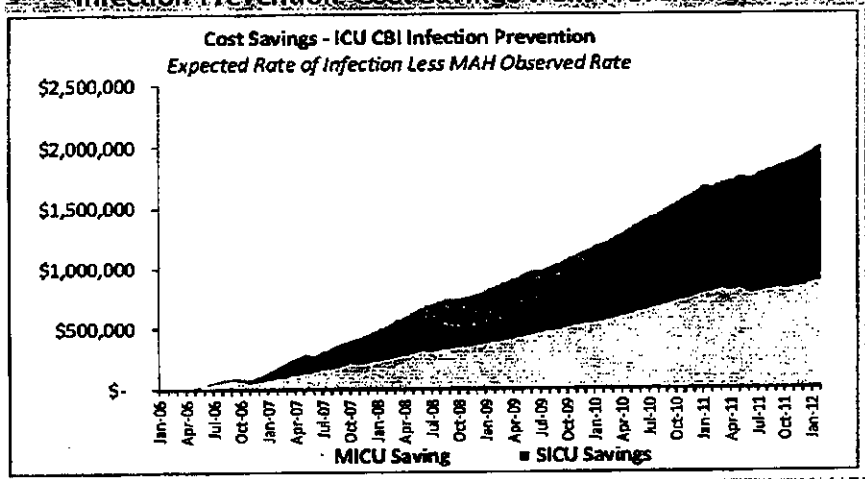
11. *Please provide any additional comments or observations you believe will help to inform our hearing and our final recommendations.*

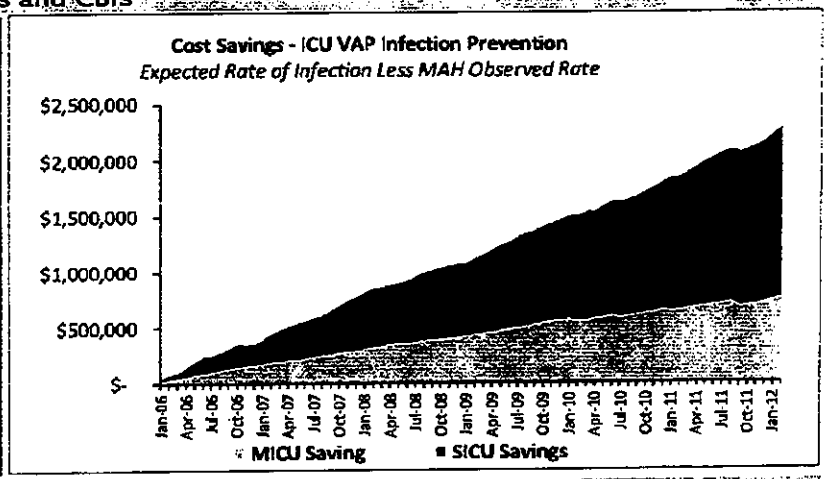
MOUNT AUBURN HOSPITAL

DASHBOARD

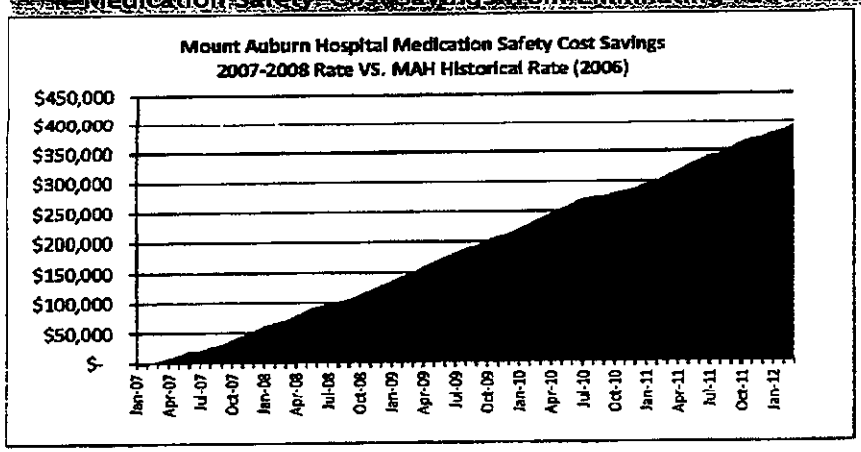
Cost and Quality

Infection Prevention Cost Savings from Preventing ICU VAPs and CBIs





Medication Safety Cost Savings from Eliminating Patient Harm Caused by Medication Error



Prevention of CBI's Cost Savings Data: January 2006 - February 2012 Hospital cost of $26,839/ patient CBI (Alleghany Control Study)	Total Savings $ 2,006,067.64
Prevention of VAP's Cost Savings Data: January 2006 - February 2012 Hospital cost of $33,000 / patient VAP (South Coast Control Study)	Total Savings $ 2,293,585.80
Med Safety Cost Savings Data: January 2006 - March 2012 Cost of $3,800 per patient harmed by med error $3,800 conservative estimate based on 1998 studies	Total Savings $ 376,789.92

Updated through March 2012

Section 8

Exhibit C
Written Testimony of the Mount Auburn Hospital
Submitted to the Division of Health Care Finance and Policy
and
Attorney General's Office
May 2012

Questions from Attorney General's Office

1. *For each year 2008 to present, please submit a summary table showing your operating margin for each of the following three categories, and the percentage each category represents of your total business: (a) commercial business, (b) government business, and (c) all other business. Include in your response a list of the carriers or programs included in each of these three margin, and explain and submit supporting documents that show whether and how your revenue and margins are different for your HMO business, PPO business, or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.*

   Exhibit 1 provides a breakdown of revenues and expenses over the requested time period for Commercial, Government and All Other payers. Payer classifications are based on D403 cost reports as submitted to the Division of Health Care Finance and Policy. A more detailed breakdown of the payers in each category is shown at the top of Exhibit 1, and a reference to the data source for each line item is shown in the right-hand column.

   Although Government payers have generated a positive net operating margin for the Hospital each year, this margin has declined significantly since 2008. Medicare rates have been more favorable than Medicaid rates, as most Medicare payments are for inpatient services (where rates are generally more favorable than for outpatients) and also include a reimbursement factor for our graduate medical education program.

   Our inpatient and outpatient per-case Medicaid rates, which dropped by 13% and 19% respectively between 2008 and 2010, remained essentially flat in FY 2011. This contributed to a significant decline in our Government operating margin in 2009 and 2010 and resulted in Medicaid rates which are now well below our cost of providing services.

   A small increase in the Government margin in FY 2011 was due primarily to a $2.5 million Medicare incentive payment for "meaningful use" of electronic health records. This is a temporary payment which is scheduled to decline each year and expire entirely by 2016. Without this payment, Government margins would have continued to decline in 2011 as they did in 2009 and 2010.

   The FY 2011 Commercial margin includes a prior year settlement gain of $2.75 million for one of our major risk contracts, which was attributable to calendar year 2009 but not finally paid until November 2010. The amount of this gain could not be booked prior to settlement since adequate information on our risk and quality performance was not yet available. If this amount had been booked during the period it was earned, the Commercial margin for FY 2011 would have been similar to FY 2010.

   A major reason for our positive Commercial operating margin continues to be our success in managing patient care under risk contracts, thereby generating risk surplus distributions as well as quality incentive payments. To a large extent, this represents the efforts of both the Hospital and its physician staff organization (MACIPA) to place greater emphasis on preventive services, case management and discharge planning. These efforts produced both higher surpluses and higher quality incentive payments, while at the same time allowing us to reduce inpatient hospital utilization and better control our costs of providing services. Although our operating margins are generally higher for business reimbursed through risk sharing arrangements than for other activity, we believe these arrangements also provide better incentives for high quality care and in the long run will result in reducing the overall costs of health care delivery.

AGO questions, May 2012 (continued):

2. *Please explain and submit supporting documents that show how you quantify, analyze, and project your ability to manage risk under your risk contracts (contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that do not subject you to any "downside" risk), including the per member per month costs associated with bearing risk (e.g., costs for human resources, reserves, stop-loss coverage), solvency standards, and projections and plans for deficit scenarios. Include in your response any analysis of how your costs or risk-capital needs would change due to changes in the risk you bear on your commercial or government business.*

   We perform detailed financial analyses of all arrangements before agreeing to any financial risk with third party payors. We have created financial models that begin with historic claims detail for the population to be managed. We then project changes to the historic base, including changes in rates, utilization and membership. We track our most reasonable projected model to ongoing monthly financial results during the year under risk and update the projected year end on a monthly basis, taking into consideration any lags in the data. This allows us to update our financial report and accounting for ongoing financial risk. We purchase stop loss insurance through a broker who undertakers actuarial assessments of our risk and recommends appropriate stop loss thresholds to best manage that risk.

3. *Please submit a summary table showing your advertising / marketing budget and costs for each year 2008 to present. Please explain and submit supporting documents that show the methodology you use to determine your advertising / marketing budget and costs.*

   Exhibit 2 shows Mount Auburn Hospital's total advertising expenses per year from FY 2008 through FY 2011, as well as its budgeted expenses for FY 2012. Advertising and marketing expenses are budgeted based on a marketing strategy reviewed and approved by the Hospital's President and CEO. In developing marketing materials, the Hospital places particular emphasis on disseminating educational information on a variety of health issues, so that we are striving to improve public health awareness as well as to highlight the particular services we provide.

4. *Please explain and submit supporting documents that show (a) trends since 2008 in the proportion of bad debt, as defined by M.G.L. c.118G.1, you carry on your total business, (b) your understanding of the factors underlying these trends in bad debt, including but not limited to any role of health insurance plan design, and (c) any changes you have made to your debt collection policies, practices, or expectations in light of these trends.*

   Exhibit 3 shows the Hospital's total Provision for Bad Debt expense by year, which has increased from 1.0% of Net Patient Service Revenue in 2008 to 1.4 % in 2011 and year-to-date 2012.

   In our view, the most important reasons for the increase in bad debt expense since 2008 are as follows:

   - An increase in patient copays, deductibles and coinsurance as employers and insurers implement changes in health plan design.

   - A shift in the mix of patient services from inpatient to outpatient status, which adds to patient costs since most plans (including Medicare) have a higher level of patient cost sharing for outpatient than for inpatient services.

   - The recent economic downturn which has reduced the ability of many patients to pay for services.

- Increasing complexity of plan design which has made it harder to determine a patient's financial obligation at the time of service, requiring the Hospital to bill patients at a later date when collection is more difficult.

We have responded to these trends in several ways, including:

- Assisting patients in applying for Medicaid, Commonwealth Care and other insurance programs as well as for Health Safety Net Pool assistance.

- Increased efforts to accurately identify patient financial responsibility and request payment at the time of service, rather than sending bills at a later date.

- Providing comprehensive financial counseling services, including assistance in developing repayment plans for patients.

- Continuing efforts to improve the accuracy of the information obtained at registration, reducing the incidence of payment delays due to denials and re-billing.

MOUNT AUBURN HOSPITAL | **All numbers in $000s** | **Exhibit 1**

QUESTION 1: OPERATING MARGIN BY CATEGORY, 2008-2011

PREPARED FOR OFFICE OF THE ATTORNEY GENERAL, MAY 2012

Commercial: All Managed Care and Non-Managed Care payers (columns 10 and 11 in D403 Sch VA)
Government: Medicare, Medicaid, Other Government, Commonwealth Care, Health Safety Net (col. 3, 4, 5, 6, 9, 13, 14 in D403 Sch VA)
All other: Workers Compensation, Self Pay, Other (columns 7, 8, 12 in D403 Sch VA)

COMMERCIAL

Line #		FY 2008	FY 2009	FY 2010	FY 2011	Source
1	Gross patient service revenue	244,657	249,778	254,651	267,915	D403 Sch VA, line 44
2	Net patient service revenue	127,132	133,314	138,471	145,806	D403 Sch VA, line 52.01
3	Patient care expenses	(116,291)	(118,279)	(120,577)	(124,893)	Total from below, allocated by gross revenue
4	Provision for bad debt	(775)	(818)	(1,267)	(1,226)	D403 Sch VA, line 53
5	HSN Pool assessment	(2,040)	(2,380)	(2,156)	(1,836)	Total from below, allocated by gross revenue
6	Total net operating margin	8,026	11,836	14,472	17,851	Line 2 less lines 3-5
7	Percent of total GPSR	48%	46%	45%	46%	Line 1 above as % of total hospital gross patient revenue

GOVERNMENT

Line #		FY 2008	FY 2009	FY 2010	FY 2011	Source
1	Gross patient service revenue	253,845	272,642	295,523	296,786	D403 Sch VA, line 44
2	Net patient service revenue	128,258	135,442	142,850	142,795	D403 Sch VA, line 52.01
3	Patient care expenses	(120,658)	(129,106)	(139,930)	(138,352)	Total from below, allocated by gross revenue
4	Provision for bad debt	(1,139)	(577)	(705)	(1,327)	D403 Sch VA, line 53
5	HSN Pool assessment	0	0	0	0	Not applicable to government payers
6	Total net operating margin	6,461	5,758	2,215	3,116	Line 2 less lines 3-5
7	Percent of total GPSR	49%	51%	52%	51%	Line 1 above as % of total hospital gross patient revenue

ALL OTHER

Line #		FY 2008	FY 2009	FY 2010	FY 2011	Source
1	Gross patient service revenue	15,315	16,798	17,108	17,158	D403 Sch VA, line 44
2	Net patient service revenue	6,985	10,984	10,033	10,131	D403 Sch VA, line 52.01
3	Patient care expenses	(7,279)	(7,955)	(8,101)	(7,999)	Total from below, allocated by gross revenue
4	Provision for bad debt	(671)	(1,900)	(1,382)	(1,584)	D403 Sch VA, line 53
5	HSN Pool assessment	(128)	(160)	(145)	(118)	Total from below, allocated by gross revenue
6	Total net operating margin	(1,093)	970	406	431	Line 2 less lines 3-5
7	Percent of total GPSR	3%	3%	3%	3%	Line 1 above as % of total hospital gross patient revenue

TOTAL

Line #		FY 2008	FY 2009	FY 2010	FY 2011	Source
1	Gross patient service revenue	513,816	539,218	567,282	581,859	D403 Sch VA, line 44
2	Net patient service revenue	262,375	279,739	291,354	298,732	D403 Sch VA, line 52.01
3	Patient care expenses	(244,228)	(255,340)	(268,607)	(271,244)	D403 Sch II line 116 col 10, plus investment & gains portion of expense offset in line 121 (from Sch VII lines 30 & 35)
4	Provision for bad debt	(2,585)	(3,295)	(3,354)	(4,138)	D403 Sch VA, line 53
5	HSN Pool assessment	(2,168)	(2,540)	(2,300)	(1,953)	D403 Sch II line 123.01 col 10
6	Total net operating margin	13,394	18,564	17,093	21,397	Line 2 less lines 3-5

Exhibit 2

MOUNT AUBURN HOSPITAL
QUESTION 3: ADVERTISING AND MARKETING EXPENSE, 2008-2012
PREPARED FOR OFFICE OF THE ATTORNEY GENERAL, MAY 2012
All numbers in $000s

Line #		FY 2008 actual	FY 2009 actual	FY 2010 actual	FY 2011 actual	FY 2012 budget	Source *
1	Total advertising expense	1,241	1,194	984	1,033	1,289	Hospital records
2	Total operating expnese	259,229	273,916	285,516	289,377	305,415	Audited financial statements
3	Advertising share of total operating expense	0.48%	0.44%	0.34%	0.36%	0.42%	Line 1 divided by line 2

Advertising expense: all costs charged to expense code 64090, excluding Human Resources advertising costs for employee recruitment.

* FY 2012 budgeted amounts are taken from internal Hospital records.

Exhibit 3

MOUNT AUBURN HOSPITAL
QUESTION 4: BAD DEBT EXPENSE AS PERCENT OF NET REVENUE, 2008-2012
PREPARED FOR OFFICE OF THE ATTORNEY GENERAL, MAY 2012
All numbers in $000s

Line #		FY 2008	FY 2009	FY 2010	FY 2011	FY 2012 Apr YTD	Source *
1	Total bad debt expense	2,585	3,295	3,354	4,138	2,435	D403 Sch VA line 53
2	Total net patient service revenue	262,375	279,739	291,354	298,732	175,487	D403 Sch VA line 52.01
3	Bad debt expense as percent of net patient revenue	1.0%	1.2%	1.2%	1.4%	1.4%	Line 1 divided by line 2

* FY 2012 year to date amounts are taken from the Hospital's unaudited internal financial statements.